

Application Intensive medical rehabilitation

More information is ava			se make sure to complete the essary documentation.	form carefully. Attach all
			may contact you for further info	ormation if necessary.
If you have questions, pumber (www.kela.fi/ca	please call our customer service all-kela).	Send	d the application and any suppaddress is Kela, PL 10, 00056	porting documents by mail.
If you are going abroad, ale When to apply: Compensation	and and you have not previously cla so complete form Y 38e. In for the cost of rehabilitation servic lication for rehabilitation arrives at h	es can be provide		
Personal identity code	Family name and given name			
Telephone	E-mail			
Street address				
Postal code	Postal district			
2. Application				
	for should be based on a rehabilitat	tion plan drawn ur	hy a public healthcare provid	ler
In line with the rehabilitation plan		son plan drawn ap	by a public floatatouro provid	01.
therapy, please complete se		itation or adaptatio	on training course, please com	plete sections 2–7 and 10
multidisciplinary individual r	ehabilitation, please complete secti	ions 2–8		
	ected by an illness or a disability wh	nich is due to		
a traffic accident	an accident at work/occupation		a military injury/se	ervice-related illness
State the name of the insurance	company and the accident numbe	r:		
3. Native language				
What is your native language?				
Finnish Yes Swedisl		e, please specify		
•	istance, complete form KU 106e			
If your native language is of providers or other government	ther than Finnish, Swedish or Sámi ent agencies?	, are you able to o	communicate in Finnish or Sw	edish with healthcare
Finnish Yes Swe	edish Yes other langu	uage, please spec	cify	
If a family member or othe KU 106e.	r person close to you participates in	n the rehabilitation	process and needs interprete	er assistance, complete forn
4. Employment and ed	ucational status			
l am under school age and cared	for at under school age and	d cared for in a da	y care centre/family day care	in school/a student
home a stay-at-home mother or fa	ather employed unen		sabled for work (on sickness	on rehabilitation
on disability pension	retired on a pension (owance) ity pension)	subsidy Other, please specify
Occupation:				
ACCHOMION				

5. Treatment of illness and planning of rehabilitation
The following organisation is responsible for my treatment and the planning of the rehabilitation
healthcare centre hospital outpatient clinic/specialised medical care
other, please specify:
Name of the healthcare unit
6. Need of rehabilitation and assistance
How does the illness or disability make it more difficult to cope with work, studies and everyday activities?
What kind of assistive devices do you use and do you use communication methods to replace speech?
Which everyday activities do you need assistance or guidance with? Describe briefly what type of assistance or guidance you need.
7. Aim of the rehabilitation
How do you wish the rehabilitation to help maintain and improve your ability to cope with everyday life?
8. Multidisciplinary individual rehabilitation
For information on the rehabilitation provider's business location, please visit www.kela.fi/palveluntuottajahaku. Select the rehabilitation provider you are interested in.
If you cannot choose a rehabilitation provider, you can leave this section empty. We will contact you about your application.
in you cannot choose a foliabilitation provider, you can loave the decision empty. We will contact you about your application.
Service provider
Service provider
Service provider Explain why you are applying for multidisciplinary individual rehabilitation and what you expect from the rehabilitation.
Service provider Explain why you are applying for multidisciplinary individual rehabilitation and what you expect from the rehabilitation. I will stay overnight at the service provider's premises during the rehabilitation (rehabilitation with accommodation).
Service provider Explain why you are applying for multidisciplinary individual rehabilitation and what you expect from the rehabilitation. I will stay overnight at the service provider's premises during the rehabilitation (rehabilitation with accommodation). I will not stay overnight at the service provider's premises during the rehabilitation (rehabilitation without accommodation).

9. Therapies					
For information on kela.fi/pa	therapy providers, please visit alveluntuottajahaku. Select the therapy provider and agree on the start of the therapy.				
Therapy that I wish to apply for	Name of therapy provider (company, firm) and business location	Starting date, if known			
physiotherapy					
speech therapy					
occupational therapy					
psychotherapy					
music therapy					
aquatic therapy					
equine-assisted therapy led by a physiotherapist					
equine-assisted therapy led by an occupational therapist					
art psychotherapy					
neuropsychological rehabilitation					
counselling visits					
If you are applying for counselling visits for parents and/or providing of therapy at some other place than the therapist's premises, this must be included in the rehabilitation plan.					
10. Rehabilitation or adaptation training course					
For information on	Number of the course				
Which course are you a	pplying to?	(if known to you)			
Course location		Start date			
If you are applying for a	family course or couple's course, state the names and dates of birth of the participating to	amily members.			
During the course,	will stay overnight at the service provider's premises.				
	I will not stay overnight at the service provider's premises. in a course related to the same illness before, please explain why a course with similar c	ontent should be arranged			
again.	in a course related to the same limess before, please explain why a course with similar c	ontent should be arranged			
Are you aware of any fa	ctors that could affect the timing of the rehabilitation (for instance surgery, holiday, travel)	?			
No Yes; please describe them and state how they could affect the timing.					

<u>11.</u>	Enclosures					
	Rehabilitation plan drawn up by a public healthcare provider.					
	Has already been submitted to Kela.	I will submit the document at the latest by				
		I have a doctor's appointment scheduled for				
	Other documentation, indicate which.					
12.	Additional information					
<u>(i)</u>	Write the number of the section you are referri	ing to.				
	Additional information on a consult about Mai	to your name and passaged identity and a so the about				
	·	te your name and personal identity code on the sheet.				
	Signature					
	clare that the information I have given is true be and date Signature and p	e and accurate. I will notity any changes. rinted name of the client				
14.	Person who can give additional info	ormation				
<u>(1)</u>	If you wish, you can designate a person whom	n Kela can contact for additional information when needed.				
	I give my consent to have additional information	n needed for the application case requested from the person mentioned in the following.				
Nan	ne and telephone number					
0	2-1	Ports the constraint				
Offi	cial position and place of work or family relations	ship to the applicant				

Kela has the right under law to access or disclose information required to decide a rehabilitation case and to implement the rehabilitation.

Information obtained for the purpose of deciding the present matter may be used for other benefit-related matters, if so required under law. Any information obtained within the context of another benefit may also be used to decide the present matter.

Please contact us for more information about which outside sources we may access to obtain additional information about your circumstances and to whom we may provide such information.